Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL208692300M
Compliance #: HL208691354C

Date Concluded: September 24, 2024

Name, Address, and County of Licensee Investigated:
Silvercrest Properties-Village Shores
6501 Woodlake Drive 901B
City, MN, Zip Code
Hennepin County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Yolanda Dawson, RN
Special Investigator

Finding: Inconclusive

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected a resident when a fire started in the resident's apartment. The resident required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although facility staff stored a medication box on top of the resident's stove, because of the damage to the medication box, a coffee maker, and the knobs on the stove, a source of the fire could not be determined.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records, emergency action plan, policies and procedure, facility fire report, and the fire department report. Also, the investigator observed location of fire alarms, evacuation postings, and fire extinguishers.

The resident resided in an assisted living facility. The resident's diagnoses included Parkinson's, muscle weakness, and history of falling. The resident's service plan included assistance with medication management, and transfer assistance. The resident was non-ambulatory and required frequent supportive nursing care and observation.

One afternoon, the fire alarm sounded in the facility and alerted staff that the alarm was coming from the resident's apartment. The fire department arrived, managed the fire, and removed the resident from her apartment.

The fire department report indicated the location of the fire was above the stove top and to the adjacent cupboards. A sprinkler above the stove activated and controlled the fire. There was a melted plastic toolbox on the stove, to the left of that a melted coffeemaker, and the knobs of the stove were melted so it could not be determined if the oven top was in the on position. The fire department could not determine whether the oven top or coffee maker were the source of the fire.

The resident's record indicated the resident was transported to a hospital with a diagnoses of smoke inhalation.

During an interview, unlicensed personnel stated she gave the resident her medications that afternoon and placed the plastic toolbox that contained the resident's medication back on the stovetop after giving the resident her medications.

During an interview, the resident stated she was sitting on her couch when she saw flames burst in the kitchen and the next thing she knew, she was covered with ice water from the sprinklers. The resident stated she did not try to stand up or remove herself from the room, because she was distracted by the cold water.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
An internal investigation was completed. Staff were reeducated on fire emergency protocol and medication box storage.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20869	A. BUILDING: _____ B. WING _____	C 06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST PROPERTIES LLC	6501 WOODLAKE DRIVE RICHFIELD, MN 55423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments On June 12, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL208691354C/#HL208692300M. No correction orders are issued.	0 000		